bulletin

NATIONAL TUBERCULOSIS ASSOCIATION

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Medical Education: Cornerstone of TB Control (page 18)

Medical Education: Cornerstone of TB Control

by William B. Tucker, M.D.
Director, Tuberculosis Service, Veterans Administration

In its broadest sense, the term "medical education" is a very inclusive one. Physicians have long known that to practice medicine proficiently is to spend their professional lifetimes continuously studying to keep abreast of new developments. What is true of medicine as a whole is even truer in the field of tuberculosis and pulmonary diseases. In few other fields have advances been coming so rapidly in recent years. And relatively speaking, there is more "catching up" to do in medical education in this field than in many others, because pulmonary diseases have received less emphasis at the undergraduate and immediate postgraduate levels.

The American Trudeau Society, medical section of the National Tuberculosis Association, has properly recognized that an effective program for the control and treatment of tuberculosis and related pulmonary diseases rests in large part upon an effective program of medical education. The creation of its Division of Medical Education, under the guidance of a director of medical education, and a larger budget than that available a few years ago, are evidences of this support.

Generally, efforts to improve medical education are directed toward two separate groups of physicians or physicians-to-be: (1) the man who is through his formal periods of training and already in practice; and (2) the man still in training, at either the undergraduate or postgraduate medical level. Each, obviously, requires a different approach.

The Division of Medical Education has supported many different lines of approach to the former, and may be expected to continue to do so, testing new techniques, discarding others, and displaying its ready inventiveness upon occasion. At the present time, the American Academy of General Practice is sponsoring for credit certain courses that include much valuable information in the field of tuberculosis and pulmonary diseases, and these are proving to be one of the most effective methods of reaching this group of physicians. However, we need to find ways to interest a greater number of physicians in practice in availing themselves of such opportunities, and possibly to support them financially in doing so whenever indicated.

Whatever the results of such efforts at the later postgraduate level, it is equally important, if not more important, to support most vigorously the best type of medical education when the physician is in his formative educational period. Thus, every means should be found for strengthening teaching programs in pulmonary diseases, including tuberculosis, in the medical schools of this country. A recent survey has disclosed that much improvement has occurred in this area in the past few years, but clearly much more is needed. The combined efforts of the NTA, the ATS, and constituent and local associations of the NTA have contributed materially to this improvement. Medical schools have welcomed this support and concur in the conviction that since the early years of medical education set the pattern, in general, for a physician's practice, there is no better time in which to concentrate educational efforts.

Thus, the Division of Medical Education believes that it is increasingly desirable to expand its fellowship program in medical education. A greater number of fellowships will attract a larger number of physicians interested in training in pulmonary diseases and tuberculosis. The interest in such fellowships appears to be greater than the supply. Trudeau fellowships are directed primarily toward potential teachers in the field, and it may be expected that funds expended in such a manner are to an appreciable extent self-perpetuating and reproducing.

Medical education and medical research work hand in hand in producing the well-trained physician. Expanded investments along both lines should lead, inevitably, to greatly improved results in the treatment and control of tuberculosis.

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How Can We Promote Medical Education?

Tuberculosis control tomorrow depends upon the education of medical students and physicians today. TB associations can help meet this challenge

by Robert H. Browning M.D.

Dr. Browning is director, Ohio Tuberculosis Hospital, and professor of medicine (chest diseases), The Ohio State University College of Medicine. From 1931 to 1948, he was administrator and medical director of Sunny Acres, Cuyahoga County Tuberculosis Hospital. He received his A.B. from Oberlin College and his M.D. from Western Reserve University. His article was solicited by the Committee on Medical and Public Relations of the American Trudeau Society.

The teaching of pulmonary disease has been badly neglected in many, perhaps most, medical schools. This subject is commonly a weak second cousin in those departments of medicine that lack a qualified, interested teacher, time in the curriculum, and an adequate number of patients available for clinical teaching. Tuberculosis hospitals are frequently at a distance from the school, so that students have little or no opportunity to acquire the medical lore to be found so easily in a well-conducted tuberculosis unit.

Most of our tuberculosis specialists in the past have come from the ranks of young physicians who were tuberculosis patients themselves. Now that the incidence of tuberculosis in medical students and residents is much reduced, this source of supply has disappeared. In the meantime, the tuberculosis specialist has broadened his potential and with additional training has become a specialist in pulmonary diseases.

Is Supply Sufficient?

Are there enough specialists in pulmonary diseases in this country? The American Medical Directory of 1956 lists 1,055 physicians whose practice is limited to pulmonary diseases. Of these, 125 are certified by the American Board in Pulmonary Diseases. A second group of 507 mention a special emphasis on pulmonary disease in their practices. Of this total of 1,562 part- or full-time specialists, 261 are in governmental service. The total seems small for a population of 170 million. It might also be noted that while the tuberculosis problem may be shrinking somewhat, the total field of pulmonary diseases is enlarging with the aging of the population.

The fact remains that much of the medical work in pulmonary diseases, including tuberculosis case finding and treatment, is and will be performed not by pulmonary disease specialists, but by practitioners who may not have much interest or current knowledge in this field.

This does not mean that all practitioners should be prepared to provide comprehensive care of tuberculosis and to diagnose and treat the other entities of pulmonary disease. However, the measures of tuberculosis control are *every physician's* business. Case finding continues to be the basic element in tuberculosis control. The practicing physician's contribution to the total of new cases of tuberculosis found each year is essential. To use the three simple methods of diagnosis—skin testing, chest X-ray examination, and bacteriological study—seems elementary. Yet we observe their frequent neglect with resultant delay in diagnosis.

In contrast, differential diagnosis and treatment of pulmonary disease, including tuberculosis, are the business of a general practitioner or of a specialist in this field who has by interest, training, reading, and experience made himself competent in it. Many a general practitioner has of necessity and almost by default become interested in pulmonary diseases, has taken over supervision of a tuberculosis clinic, and has become the community "chest man." This evolution should be encouraged and promoted by tuberculosis associations when the welfare of the community will be served and the physician in question has real potential.

The small group of physicians with a *special interest and experience in pulmonary disease* represent a wide variety of backgrounds and skills. These men need to be able to perform or secure many specialized examinations for their patients: bronchoscopy, bronchography, planigraphic and other nonroutine X-ray examinations, laboratory studies involving animal inoculations and cultures, tissue examination following lung biopsy, etc. They require the temperament, time, and knowledge to provide "comprehensive care" for the chronic cases of pulmonary disease. Ideally, their distribution would make at least one of their number accessible to every community. To them should be entrusted the diagnosis of the "problem case" of pulmonary disease. To them for treatment should go the patients with diagnosed tuberculosis after their period of hospital treatment is completed. Patients with many other types of pulmonary disease will appear in their offices.

Assuming that our needs have been

fairly stated and that they are far from being met, what can we do to remedy matters? There are many avenues of approach, but the one predominant and almost universal need is for better teaching of pulmonary diseases in medical schools and hospitals. In 1956 there were 23,600 residents and interns in training in all fields of medicine and 28,748 medical students in 83 medical schools. It is from these groups of future practitioners that physicians interested in tuberculosis and pulmonary disease must be recruited.

Here we have a captive audience attuned to the learning process, susceptible to the enthusiasm of a good teacher, forming the attitudes and interests that are likely to persist throughout professional life. Here also we have strong competition for the student's interest from teachers in other medical fields. This is as it should be, with the student finally selecting his pattern of practice according to his aptitudes and opportunities.

The important thing is that medical students be exposed to basic teaching in pulmonary diseases in every medical school in the land. Interest in this field will not be generated in a vacuum. Assigned time in the curriculum, competent teaching personnel, and clinical material (patients) are the necessary ingredients in this recipe.

Some Startling Facts

A recent appraisal by the American Trudeau Society, Division of Medical Education, of 74 approved medical schools in the United States brought answers to questions about pulmonary disease teaching from most of them. The first 69 reporting revealed the following startling facts:

Thirty-five per cent have no organized division for teaching pulmonary disease.

Thirty-eight per cent have no organized division for teaching thoracic surgery.

Forty-six per cent offered their students no opportunity for clinical experience on a pulmonary disease or tuberculosis ward.

Here, then, is *the* most important place in medical education for tuberculosis associations to use their funds and influence. They can purchase "insurance" that tomorrow's interns, residents, and practitioners will have basic knowledge in pulmonary disease and that those with special interest will develop into teachers and specialists.

Already seven state tuberculosis associations are subsidizing salaries for teaching pulmonary diseases in medical schools. Three other state associations are planning to do so soon. Six local associations are contributing to the salaries of medical school teachers.

Once medical students graduate, the problem becomes vastly more difficult. They scatter to more than 1,200 hospitals for internships and residencies and then to thousands of communities. Much of the pattern of their professional lives is set, and it becomes a most difficult problem to claim their attention toward medical information which is not in line with their major interest.

What Can Be Done

Some techniques that have been used among medical graduates to promote medical education in pulmonary diseases are listed below.

1. Residencies or fellowships in pulmonary diseases can be developed. Ten state and local tuberculosis associations are contributing to the support of ATS Teaching Fellows. Some of these will be our medical school teachers of the future. This is one of the best ways to make Christmas Seal dollars count. The program is usually coordinated by the ATS Division of Medical Education.

2. Circuit riding postgraduate programs may be given in many areas in a state. This has been done successfully by the University of Kansas and is one way to reach the family physician who does not find it practical to go far from home for such training.

3. Circulation of "TB Abstracts" should be broadened.

4. Subscriptions to THE AMERICAN REVIEW OF TUBERCULOSIS AND PULMONARY DISEASES should be provided when needed to the libraries of medical schools or medical societies.

5. Postgraduate courses in pulmonary diseases for general practitioners can be a successful device. Tuberculosis associations can arouse the interest of a local physician by offering a scholarship, together with travel and maintenance expenses, to attend an established course. This type of assistance might be of real value in small communities where trained specialists are not available and where it is important to have one man who is interested and competent in this field.

6. Medical societies, both state and local, should have tuberculosis or pulmonary disease committees or sections. At times, tuberculosis associations can help to promote organizational structures that will lead to official interest by the society in these problems and to the inclusion of pertinent presentations at medical meetings.

7. Cooperative action with health departments is often fruitful. The encouragement of X-ray surveys, laboratory services, clinics, and free tuberculin for use by the profession are all items which might be discussed with health department officials. These services will tend to kindle the interest of the practitioner in the better handling of pulmonary diseases.

8. At times, local tuberculosis associations can arrange and support summer clinical experience in tuberculosis hospitals for medical students who have a free summer period.

9. Local, state, and national divisions of the American Academy of General Practice should be encouraged to include interesting topics regarding pulmonary diseases in their programs.

10. As in all fields of medicine, articles in the field of pulmonary diseases should be published in medical journals.

11. The development of teaching programs for interns and residents in the hospitals of their appointment is a most important approach to this particular group of physicians.

Planning, promoting, and financing to arouse interest in pulmonary diseases in general practitioners and in future practitioners will help to assure your community an adequate number of physicians qualified to manage patients with tuberculosis and other pulmonary diseases.

5 Steps to Better Management

by Charles J. Meyers

Mr. Meyers is director of education, Arvin Industries, Inc., Columbus, Ind., and a member of the executive committee of the Indiana Tuberculosis Association. His article was solicited by the Governing Council of the National Conference of Tuberculosis Workers.

No matter how commendable our goals, we cannot expect to achieve them unless we know and apply the basic principles of managing our work and other people

All of us are managers—whether we are the executive of a small tuberculosis association with only volunteer help, or a public health official with a trained staff of several dozen people. Whether the undertaking is simple or complex, large or small, the essential functions of management are always present.

What are these functions of management?

Setting the objective. All the activities of a manager are concerned with ultimately accomplishing some specific result. Ways and means must, therefore, be found in each situation to intelligently gain the best efforts of people in using materials and machines in order to arrive at a predetermined goal.

Whether general or specific, whether for short duration or for the long pull, whether involving many people or one individual, objectives must be set if the best results are to be obtained. Objectives serve as guides to keep an organization on the right road and to eliminate waste of time, effort, and money.

Planning for action. The preparation of a plan of action to achieve a specific goal is one of the most difficult and most important tasks of every organization. It is, in effect, an order to carry out the predetermined objective. In planning, the manager indicates the various actions to be taken. He fixes the share of responsibility for each operation, coordinates the parts, and thus harmonizes the whole, indicating in detail the line of conduct to be followed. Absence of a plan means hesitation, false steps, untimely changes of direction, and sometimes disaster.

The three basic elements of a good plan are unity, continuity, and flexibility.

Unity of plan is important. To achieve an objective, only one plan can be put into operation at a time. Two different plans would mean confusion and disorder. However, a plan may be divided into several parts. These several parts are linked or welded to make up one, and only one, master plan, and every modification brought to bear on any one of them is reflected in the whole plan.

The plan must be continuous. The limitations of human foresight necessarily set bounds on the duration of plans. In order that there be no break in the guiding action, a second plan must follow immediately upon the first, and a third upon the second, and so on.

The plan should be flexible enough to bend before courting disaster. If decisions are made in the light of certain facts and some of these turn out to be ill-founded, it is always possibly to modify the plan in accordance with new circumstances and new situations.

Organizing for action. The work to be done, the people to do it, and the work place, including the area and equipment, are the three factors to consider in organizing for action. The manager should:

1. Insure that the plan is properly prepared and strictly followed.
2. See that the personnel and material available are consistent with the objectives, resources, and requirements of the organization.
3. Set up a single, competent, energetic guiding authority.
4. Harmonize activities; coordinate efforts.
5. Formulate clear, distinct, concise decisions.
6. Arrange for efficient selection of people for the jobs to be filled.
7. Define duties clearly.

For any action whatsoever, a person should receive orders from one superior only. This is often referred to as the rule of "unity of command." When this rule is violated, authority is undermined, discipline is in jeopardy, and stability is threatened.

Another rule to be considered is "unity of direction" — which means one head and one plan for a group of activities having the same objective. It is the condition essential to unity of action, coordination of strength, and the focusing of effort.

Organization must take place before personnel can be properly selected and trained. It should take place before there is any action.

Motivating for action. Motivation is the means by which the manager creates and maintains the desire of his people to achieve the planned goals. Since this is such a broad area and so much has been written about it, only a few points will be made.

People may be motivated by proper job instruction:

1. Preparing the worker—putting

him at ease, finding out what he knows about the job, getting him interested in learning the job.

2. Presenting the operation—telling, showing, and illustrating carefully what is to be done; stressing key points; and taking just one step at a time.

3. Trying out his performance—having him perform the operation; having him tell, show, and explain the key points by asking questions and correcting errors until you know that he knows the job.

4. Following up—putting him on his own, indicating whom he should go to for help, then checking with him frequently.

Another means of motivation is getting the group to participate in analyzing the problems and making the decisions. By participation, people are encouraged to share the responsibility of the activity.

Action means motion. Therefore, some friction is bound to develop. It can best be avoided by:

1. Showing proper respect for the individual.
2. Providing the work group with information and understanding.
3. Recognizing individual effort.
4. Instilling a desire to excel.

When a problem does present itself, disrupting the harmony of the group, the following formula can be helpful in arriving at a solution:

1. Get the facts by reviewing the record, talking to the individuals concerned, getting opinions and feelings, being sure that you have the whole story.

2. Carefully evaluate the facts by fitting them together and considering what possible action might be taken and its effect both on the individuals and on the entire group, being sure not to jump to conclusions.

3. Take action, having consulted with any superior who might be involved and giving consideration to the timing of the action.

4. Check the results, following up on the action that was taken, watching for changes in attitudes and relationships, always asking, "Did the action get the desired results?"

Controlling the action. Control must operate on everything—things, people, actions. To be effective, control must be used within a reasonable time and be followed up by proper corrective action. Obviously, if the conclusions derived from checking activities, however efficient, come to hand too late to be of use, or are not followed up, control will have been a futile activity.

Powers and limits of control must be defined at the outset as precisely as possible. In the planning stage, it is essential that some consideration be given to the standards by which the actual performance can be judged, and all deviations from these standards should be analyzed.

In any undertaking, control consists of verifying whether everything occurs in conformity to the plan adopted, the instructions issued, and the principles established. Its objective is to point out weaknesses and errors in order to rectify them and prevent their recurrence.

Leadership is a challenge to the best that is in any individual. Official authority alone does not, of course, make anyone a leader. Instead, he must possess intelligence, experience, moral worth, and, to a high degree, the ability to apply the principles of management to whatever task he undertakes.

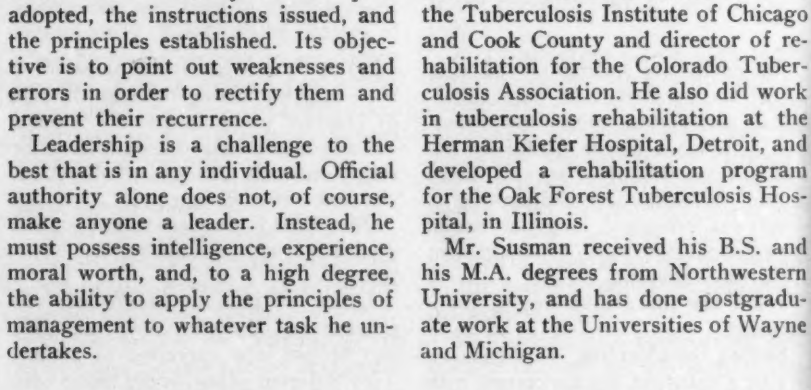
Ralph Susman

NTA appoints new director of its Rehabilitation Division to succeed Ryrie Koch

Ralph W. Susman, who has been an associate in the Division of Rehabilitation of the National Tuberculosis Association since 1956, has been appointed director of the division. He succeeds A. Ryrie Koch, who resigned in September to become a regional representative for the Office of Vocational Rehabilitation, in Boston.

Before joining the NTA, Mr. Susman was rehabilitation director for the Tuberculosis Institute of Chicago and Cook County and director of rehabilitation for the Colorado Tuberculosis Association. He also did work in tuberculosis rehabilitation at the Herman Kiefer Hospital, Detroit, and developed a rehabilitation program for the Oak Forest Tuberculosis Hospital, in Illinois.

Mr. Susman received his B.S. and his M.A. degrees from Northwestern University, and has done postgraduate work at the Universities of Wayne and Michigan.



New TB Unit in Idaho

THIS $1,021,346 addition to the Idaho State Tuberculosis Hospital, at Gooding, Idaho, will allow replacement of 40 beds housed in temporary buildings and will increase the total hospital capacity from 90 to nearly 150 patients. Dedicated last summer, the new brick, concrete, and steel structure is connected with the original building, which was opened in 1947.

Green Suit Day

To help tuberculosis patients make the difficult transition from bed rest to ambulatory status, an ingenious program has been developed at a VA hospital

by

V. J. Greenwood and **George Calden Ph.D.**

Mr. Greenwood is chief, Special Service, Veterans Administration Hospital, Madison, Wis., in which position he supervises the Recreation and Library Sections. He is also chairman of the Voluntary Services Program. Dr. Calden is chief clinical psychologist of the same hospital. In addition, he is a lecturer in psychology at the University of Wisconsin and the author of the Madison Sentence Completion Form, a psychological test for determining the tuberculosis patient's attitudes.

One of the most important events in the life of the tuberculosis patient in a Veterans Administration hospital is the day he sheds his pajamas and puts on his green suit. The donning of the green convalescent suit symbolizes the beginning of the end of the patient's hospitalization. He is graduating from the long, confined stay in one of the bed-rest wards and is entering into the final ambulatory phase of convalescence. To the patient, however, the "wearing of the green" means not only that physical recovery is in sight, but also that he now can get back on his feet, move about, meet people, engage in more active rehabilitation projects, and make specific plans for the future.

The Madison Program

The staff at the Veterans Administration Hospital of Madison, Wis., sensing the importance of this turning point in the patient's treatment, has initiated an educational and social program in order to give this graduation the recognition and dignity it deserves. Every two weeks, on alternate Tuesdays, the carpet is rolled out for the new "green suiters" in the form of a Green Suit Day. On this day, groups of from four to twelve patients who have graduated into ambulatory status during the previous two weeks are invited to participate in the Green Suit Day activities.

The first Green Suit Day was celebrated on Tuesday, October 25, 1955. During the first year and a half after its inception, approximately 225 newly graduated patients were honored in this fashion.

On the morning of Green Suit Day, each new green suiter is given a program printed on green paper. The cover sheet of the program shows a cartoon of a green-suit patient holding a huge key labelled "Green Suit Day—the Key to a Happy Future." On the back is a cartoon of a patient in civilian clothes proudly displaying his MHB (maximum hospital benefit) discharge notice. A message of congratulation by the hospital manager is included in the inside page. This is followed by a listing of the program of events for the day.

At 8:30 A.M., the medical head of the Physical Medicine and Rehabilitation Service is the first staff member to greet and address the new ambulatory patients. In his talk, he stresses the importance of using the remaining months of hospitalization in a constructive and productive fashion. The three major purposes of the green-suit phase of rehabilitation are stressed: (1) the need to build up the patient physically and restore his strength, (2) the need for resocialization—to draw patients out and help them feel at ease with other people again, and (3) the need to plan for future employment through exploratory training in the rehabilitation clinics and the various hospital services, as well as through vocational counseling both within and outside the hospital.

The psychologist then discusses the Green Suit Day program with the patients and explains the hospital's organizational structure. The objective of this discussion is to help foster a greater feeling among patients of hospital identification—the feeling that "this is my hospital." This is followed by a showing of the movie "You Can Lick T.B." The film reviews the patient's hospital treatment program, with special emphasis on the final, rehabilitation stage.

At 9:15 A.M., the new green suiters join with the Patient Council in their weekly meeting with the hospital manager, assistant manager, director of Professional Services, and the chiefs of Special Service and the Recreation Section. Toward the end of the council meeting, the manager congratulates the patients individually and welcomes them to the green-suit stage.

Coffee Break

The coffee-social hour which follows is open to all green-suit patients. The social hour is timed for the customary American coffee break, 10 A.M., and serves to lend a note of informality, friendliness, and welcome to the entire day. After everyone is served, socialization is allowed to run its course. The hospital staff is encouraged not only to attend but to mix with the green-suit patients.

After a brief introduction by the master of ceremonies, the manager introduces all the staff members present. He is followed by the president of the Patient Council, who introduces all new

green suiters and the "elder statesmen"—those patients who are about to be discharged. The VA voluntary services representative for the Veterans of Foreign Wars Auxiliary, in her role as hostess, then presents the coworkers who are assisting her. She also congratulates the new men on their graduation to the green-suit stage.

All introductions and presentations are made in an informal fashion. The ladies acknowledge birthdays with prizes, continue to refill coffee cups, and strive to draw new patients into conversation. From time to time, a disguised, comic character, masquerading as a clown or witch, adds humor and color to the hour.

Aid to Education

For medical students, interns, and physicians in practice, the *Bulletin* of the National Tuberculosis Association is a valuable means of medical education in the fields of tuberculosis and pulmonary diseases.

The Committee on Medical and Public Relations of the American Trudeau Society recommends that state and local tuberculosis associations provide subscriptions to the *Bulletin* for the libraries of medical schools, hospitals, and medical societies in their area.

—Frederick C. Warring, Jr., M.D., Chairman
Committee on Medical and Public Relations
American Trudeau Society

After the new green suiters have had their customary afternoon bed-rest period, they are taken on a tour of the hospital conducted by a nurse, the patient education coordinator. The tour starts with a trip through Central Services. The patients are shown how ward supplies are distributed, how hypodermic needles are sharpened, and how syringes and gloves are washed. There also is a demonstration and explanation of the operation of the autoclave equipment. Moving on to the pharmacy, they are shown the bulk supplies of streptomycin, PAS, and other antituberculosis drugs. The procedure for obtaining drugs when patients go on pass is explained.

The laboratory technician in the histology department demonstrates specimens of lung tissue showing cavities, calcified areas, and emphysema. Patients also have the opportunity to observe gastric cultures and to peer at the tubercle bacillus under the microscope. They visit the blood bank and are encouraged to urge their friends to donate blood to the Red Cross.

The tour ends with a visit to the nursing education unit, where the nursing affiliate and hospital aide training program is described. In addition, the patient education coordinator suggests ways of making constructive use of the green-suit rehabilitation period.

The Green Suit Day festivities serve as an acknowledgment that the patient has just left the sheltered environment of his familiar ward surroundings and is about to enter and participate actively in the broader hospital community. As one patient stated toward the close of Green Suit Day, "Before, my room with its four walls was my home. Now the entire hospital is where I live."

Many patients initially feel lost and like total strangers in this new community. Others are overly frightened by the newer, faster pace of living and frequently crawl back into bed for fear of a physical relapse. Green Suit Day, therefore, aims to help restore the patient's self-confidence and his feeling of being "at home." The greetings by the manager, the coffee-social hour, the introduction to fellow patients and staff members, have been very helpful in breaking the ice for these more timid individuals.

From a psychological point of view, Green Suit Day symbolizes the "coming of age" of the tuberculosis patient. During the many months in bed prior to this day, he had been obliged to assume the role of a child, to become a passive, receptive individual, almost totally dependent on the hospital staff. Nothing constructive was expected of him beyond a mere acceptance of his treatment.

In the light of this background, participation in Green Suit Day is intended as an important steppingstone in the patient's maturing process within the hospital. One major objective of Green Suit Day is to help him make the transition from the status of dependent bed-rester to that of an ambulant patient ready to assume adult responsibilities. Green Suit Day serves as a kickoff day. It starts the ball rolling in changing patients' attitudes from that of "you take care of me" to self-help and helping others.

Dr. Christie Gets Research Award

Dr. Amos Christie, of Vanderbilt University, Nashville, Tenn., has been notified that he will receive the John Phillips Memorial Award for research in histoplasmosis, which was conducted with the aid of grants from the National Tuberculosis Association.

The award is deemed one of the highest in medicine and is made by the American College of Physicians. The presentation will be made April 30, 1958, at the meeting of the college in Atlantic City.

Dr. Christie received medical research grants from the NTA from 1946 to 1956 for studies on histoplasmosis. A pediatrician, the physician became interested in the subject because of the number of children observed at the hospital clinic with X-ray evidence of lung calcification who did not react to the tuberculin test. Further study showed that these children had histoplasmosis, a disease now known to be endemic in the middle area of the United States.

Chest Chair for West Virginia

A chair of pulmonary diseases is being established at the West Virginia University School of Medicine at the instigation and with the support of the West Virginia Tuberculosis and Health Association and its affiliated associations and the West Virginia Trudeau Society.

The tuberculosis associations are undertaking to support the course in pulmonary diseases to the extent of $10,000 a year for three years, beginning with the fall term in 1960. At the end of that time, an evaluation will be made to determine whether the associations will continue the support for another three years.

This will be the first privately supported chair to be created for the four-year medical program, according to university officials. The course will be set up for medical students in their junior and senior years.

by Janet I. Pinner

Director of Selective Placement
New York State Employment Service

The attitudes of the employer, the worker, and the professional responsible for placement may all need changing if we are to find satisfactory jobs for the . . .

Disabled Older Worker

Anyone who has paid any attention to the wealth of material on the subject of older workers appearing in newspapers, magazines, periodicals, on radio and TV, is bound to be impressed with two facts: (1) that workers over 45 years of age are being discriminated against by employers; and (2) that if you hire an older worker, you have less turnover, less absenteeism, better production, etc.

This, of course, is institutional advertising similar to the campaigns to combat discriminatory practices against the handicapped. The groundwork must be laid and the public must be given generalized facts and figures in order to understand the long-term problem. This is fine, but does it ever backfire on us? How much of this institutional advertising is rubbing off on professional workers in the field? How many are using the propaganda line as an excuse for their inability to make placements?

Last year, the U. S. Department of Labor conducted a study on the economic aspects of the problems of the older worker in seven cities throughout the United States. This study called for the participating staff in the local Employment Service offices to assess and report upon their own attitudes and practices in placing such workers. Evidence emerged that many times it was the interviewer's attitude rather than the employer's which prevented placement of older workers. For example, when an employer gives an order for help, without specifying an age range, the interviewer may assume that a younger worker is wanted and so specifies "under 45 years" on the order. Another interviewer may assume the employer will not hire workers above a certain age because he has not been known to do so in the past. Some interviewers may have the stereotyped idea that the older worker is suitable only for certain jobs, such as baby sitting, regardless of other skills and experience.

In filling job orders, interviewers in a hurry may pass over an older worker fearing he might be a "problem." And last but not least, local offices of the Employment Service may be under such workload pressure that an incomplete job is done in interviewing and recording an older worker's experience, training, and skills.

The Workers' Attitudes

But attitudes and practices are not one-sided. What are some of the older workers' attitudes and practices that contribute to the problem? This same federal study points out that some older workers do not know how to look for a job and lack salesmanship in selling themselves. Others dislike to accept a change of occupation, industry, or even place of employment. Too many sense they are slowing down and are too prone to talk about it. Some older workers take a defeatist attitude when it comes to seeking new employment; with others, the fear of loss of prestige prevents them from taking work requiring lesser skill or paying lower wages.

What about the employers' attitudes and practices? The study points out that some employers' hiring practices—either in accepting or in rejecting older workers—are not always consistent with officially stated policies. Other employers reject older workers because they are taking care of their own older workers and cannot absorb more. On the other hand, employers add to the problem by failing to call back their older workers after what they said was to be a temporary layoff period. Some employers don't actually say they won't hire older workers, but their job specifications require a superman to fill them. Many employers show great interest in recruiting older workers but only for hard-to-fill openings, such as stenographer or typist. Some employers hesitate to hire an older worker at a lower skill or at a lower pay rate than he had in his last employment, despite the fact that this is the best level of skill at which the man can now perform.

So much for facts and practices on older workers. Now, how many of these facts apply to the *disabled* older worker? It would be logical to assume that if older workers are difficult to place, older disabled workers are twice as difficult to place. But our experiences do not bear this out.

Every year during National Employ the Physically Handicapped Week, the New York State Employment Service makes a study of the characteristics of the disabled workers applying to the local offices for service. In 1955, 43 per cent, and in 1956, 45.5 per cent, of the disabled serviced that week were over 45 years of age. In both years, 40 per cent of the placements made of disabled workers were in the over-45 group.

Compare these proportions with a survey done in April, 1957, by the New York State Employment Service. In this study, all older workers—disabled and nondisabled—composed 40 per cent of the job seekers, and they obtained only 27 per cent of the jobs.

How is it possible that disabled

older workers were able to obtain a higher percentage of placements than older workers per se? Selective placement, be it of a youngster or an oldster, is an individual, custom placement job. It is not based upon catchy slogans but involves professional counseling and placement.

Similar experience is reported by the New York State Employment Service older-worker counselors who are allowed the extra time required to work with selected nondisabled older workers. Their placement results flowing from specialized counseling and often individual job solicitation parallel those of the selective placement interviewer. In these instances the ratio of placement to intake is practically one to one.

These facts illustrate once again that in order to get results you must have qualified trained staff who have the know-how to do the work, and *sufficient time must be allotted to them so that they can do their job.* An employer cannot be approached with the idea of trying to sell him something, but rather with a settled conviction of how the disabled worker may be of use to his firm. This means the interviewer must have an intimate knowledge of the disabled worker's background and experiences. He must know what makes this person different from all other people—what his assets are, what his goals are, what his interests are, and the kind of personality he would work with best. This kind of information is not acquired from a once-over-lightly interview but requires a good professional interview, verification with past employers, aptitude tests if indicated, and a recent medical report from sources competent to evaluate the disabled person's ability to work.

It is necessary to know the employer, know what his jobs are, and know what skills and abilities they require. This background cannot be obtained over the telephone or by reading a book on occupations. It requires a visit to the employer to learn those intangibles that make the difference between a placement that sticks and one that blows up in your face. It is important to know the tempo of the plant—what the facilities are, who the foremen are, who are the workers—in addition to the skill processes involved.

The attitude of the successful selective placement interviewer toward the older disabled worker is positive. Emphasis is on how to change an employer's attitude, not on a rationale justifying the employer in not accepting this group. We have noticed that some of our more experienced staff members can give many reasons why a placement cannot be made, while a less experienced interviewer doesn't know why—so goes ahead and does it. Actually, much depends upon the motivation of the selective placement interviewer plus the amount of exploration he or she is willing to do in order to make the placement.

We have found that interviewers who are well trained to answer some of the objections raised by employers are frequently successful in demonstrating that many common beliefs and generalizations are unfounded. High-pressure salesmanship is not needed but the ability to decide when an employer should or should not be encouraged to hire the older disabled worker for his job. If the interviewer is armed with facts, he is able to discuss the problem objectively.

We have also found that our greatest success is obtained when we discuss a specific disabled older worker for a job. We never label the worker as "disabled" or "older." We talk only in terms of the worker's basic qualifications. You'd be surprised how many employers hire older workers without even thinking of them as such. Many of our employers are over 45 years old, and many would be shocked and annoyed if told they are in the "older worker" group.

Advantages of Smaller Firms

We have had better success in placing the disabled, regardless of age, with smaller firms than with large ones. Studies have proved that at least two out of every five new employees hired by establishments with eight to forty-nine workers are older workers. In firms employing one thousand or more workers, the rate is only one in four. One factor here is that the pension plans of the larger firms often militate against hiring the older worker.

We have also realized it is a mistake to generalize about workers over 45 years of age. As a group, the problem of the 45- to 50-year-olds is not the same as the over-65 group. As the age increases, the difficulty of the placement usually increases also.

Guides for Action

In summary, it may be stated that placing the older disabled worker is a difficult but not impossible task:

1. Provided the interviewing process is intensified to determine more fully all possible job qualifications, to evaluate the efforts the applicant has been making to secure work, and to explore further steps that can and should be undertaken both by the older disabled applicant and by the professional worker doing the placement.

2. Provided employment counseling techniques are thoroughly employed as necessary, in order to assist individuals in choosing a type of work that is in accord with their highest abilities and interests and yet is realistic in terms of probable employment opportunities and employer requirements, and to assist in overcoming lack of confidence and other problems interfering with successful job search.

3. Provided individual job solicitation is undertaken through personal contact with employers in behalf of an older disabled worker who possesses qualifications for which there is a need in the area.

4. Provided there is continuous effort to eliminate or modify age specifications on all job orders and to assist employers to make more realistic appraisals of physical requirements not related to job performance.

5. Provided careful prereferral interviews are arranged in order to give older disabled applicants full information on job openings to which they are being referred and to help them prepare to present their qualifications effectively.

Let's stop talking about the problems of job placement for disabled workers over 45 years of age and get ready to talk in the future about how we have licked the problem of job placement for disabled workers—regardless of age.

Tuberculosis Mortality in Europe

Recent reports from the World Health Organization give death rates for 1955 and 1950 in ten European countries. With only two exceptions, 1955 tuberculosis death rates far exceed the United States rate of 9.1 per 100,000 population; the two exceptions are Denmark and the Netherlands, where the rates were 6.3 and 6.7, respectively.

Of the ten countries studied (see table), Portugal recorded the highest rate—63.0 per 100,000 population in 1955. Nevertheless, when the tuberculosis death rate is related to the total mortality, Portugal has shown remarkable progress. In 1951, for example, tuberculosis accounted for 10.7 per cent of the deaths from all causes; in 1955, the percentage dropped to 5.6. In Denmark, which has experienced a spectacular drop in the tuberculosis death rate in recent years, tuberculosis deaths accounted for 1.5 per cent of deaths from all causes in 1951; in 1955, the corresponding figure was 0.7. In the United States, tuberculosis accounted for approximately one per cent of the deaths from all causes in 1955.

In the ten selected European countries, tuberculosis is also the leading cause of death among all infective and parasitic diseases, ranging from 49 per cent of all such deaths in the Netherlands to 81 per cent in Ireland. In this country, tuberculosis is the cause of 56 per cent of all deaths from infective and parasitic diseases.

We have become accustomed to the consistently higher death rate among males in the United States, where the death rate from respiratory tuberculosis is more than two and a half times as high for males as for females. A similar situation prevails in most of these European countries. In Denmark, Ireland, and the Netherlands, however, the ratio between the two sexes is much closer, the male rate being only one and a half times as high as the female. Generally speaking, in each of the countries considered, a greater decline has been effected among females.

These data exclude certain European countries for which comparative data were not available and which have significant TB problems.

PERCENTAGE DECLINE BETWEEN 1950 AND 1955 IN TUBERCULOSIS MORTALITY IN TEN SELECTED EUROPEAN COUNTRIES

Country	Tuberculosis death rates per 100,000 population		Percentage decline between 1950-1955
	1955	1950	
Austria	31.5	54.5	42
Denmark	6.3	13.8	54
England and Wales	14.6	36.4	60
Finland	41.8	93.6	55
France	31.3	58.1	46
Ireland	30.5	80.2	62
Netherlands	6.7	19.0	65
Northern Ireland	15.1	48.3	69
Portugal	63.0	143.6	56
Scotland	19.1	53.6	64
United States	9.1	22.5	60

Respiratory Disease

Nine members appointed to NTA Committee on Respiratory Diseases

Nine members have been appointed to the Committee on Respiratory Diseases, which was authorized by the Board of Directors of the National Tuberculosis Association in May, 1957. This committee is charged with the responsibility of studying on a continuing basis the field of respiratory diseases in order to implement the action of the Board in May, 1956, when it adopted the report of the Policy Committee on Program Extension:

"That effective action should be taken immediately by the National Tuberculosis Association to assist those state and local associations wishing to implement the policy adopted by the Board of Directors of the NTA on May 16, 1954, making the field of pulmonary diseases an integral part of the program of the NTA and its affiliates, and that this program should be extended to include the entire field of respiratory diseases."

The committee consists of two members from the Board of Directors, two from the American Trudeau Society, two from the National Conference of Tuberculosis Workers, and three at large. They are Dr. David T. Carr (chairman) and Dr. Daniel E. Jenkins (ATS); Don A. Warner and Dr. O. A. Sander (NTA); J. Irvin Nichols and M. J. Plishner (NCTW); and Dr. Robert J. Anderson, Dr. Richard L. Riley, and Rolf Eliassen.

Trudeau School to Hold 43rd Annual Session

The Trudeau School of Tuberculosis will present its 43rd Annual Session June 2-20, at Saranac Lake, N.Y. The three-week course will cover all aspects of pulmonary tuberculosis and also certain phases of other chronic chest diseases. Clinical material will be derived from nearby tuberculosis hospitals.

Since registration is limited, those who plan to attend should make early application for enrollment. The tuition is $100, and a few scholarships are available for those who qualify. Application form and more detailed information may be obtained from Secretary, Trudeau School of Tuberculosis, Box 500, Saranac Lake, N.Y.

New hope for the tuberculous as they queue up to receive aid from the Ceylon National Association for the Prevention of TB.

TB in CEYLON

Breeder of TB—malnutrition is a prime target of the CNAPT. Here a child is shown before and after getting CNAPT aid.

Under the auspices of the Rotary Club of Colombo, a group of leading Ceylon citizens formed the Ceylon National Association for the Prevention of Tuberculosis on June 17, 1948.

At that time, it was estimated that 100,000 persons in Ceylon had active tuberculosis among a population of six and a half million—or a case rate of 1,538 per 100,000. Only 1,500 beds were available in all hospitals and sanatoriums, and most patients went to them only in the last stages of the disease, expecting to die.

A CNAPT investigation revealed that most of the patients were breadwinners who hid their disease until it was too late to help them because no one else could support their family. Under these circumstances, tuberculosis control was impossible.

Hence, in 1949, the CNAPT started a program to assist the families of patients and to induce patients to seek early treatment. While granting such assistance, the association aroused public opinion and focused the people's interest on the needs of the tuberculous.

In 1953, the association succeeded in persuading the government to take over the major share of the program of tuberculosis relief. This resulted in 3,500 patients' receiving help in 1954, nearly 6,000 in 1955, 8,000 in 1956, and 100,000 in 1957.

BCG vaccine is given to a child at the Thassim Clinic, in Galle, the first out-station chest clinic in Ceylon, which was built with voluntary contributions by the CNAPT.

A home visiting team, which is a vital part of the CNAPT's program, distributes food to the tuberculous.

The CNAPT also provided from voluntary contributions a ward for tuberculous children and later a hospital for such children—the Hawke Memorial Hospital—and the first out-station chest clinic in the country. Since then, the government has built several other chest clinics with the help of funds provided by Australia under the Colombo Plan.

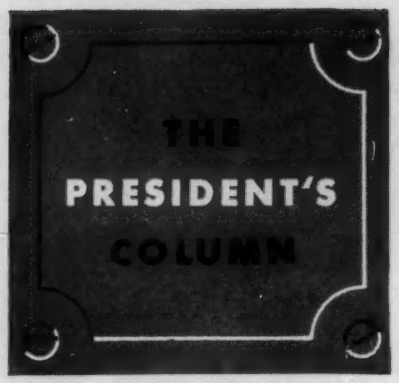
The CNAPT also grants weekly assistance to malnourished children of poor, tuberculous parents in Colombo.

Similar work on a smaller scale is done by 20 branch associations in various important population centers of Ceylon.

In spite of this notable progress, a recent World Health Organization survey revealed that there are 64,000 cases of active pulmonary tuberculosis in Ceylon excluding children 10 years and under, or a probable total of 75,000 cases. In addition, there are several thousand cases of other types of tuberculosis. Of the 75,000, only 20,000 have been detected so far; thus, 70 per cent of the cases are untreated and untreatable.

The heroic efforts of the CNAPT, coupled with the more recent help of the government and the improved treatment methods of the past decade, have gone far to improve the tuberculosis picture in Ceylon. But a tremendous job still remains to be done.

In June, 1957, the CNAPT moved into its new quarters, built by voluntary donations. In accordance with Oriental custom, the building was declared open by the lighting of wicks of a coconut oil brass lamp. At extreme right is Prime Minister S.W.R.D. Bandaranaike.



William M. Morgan, Ph.D.
President
National Tuberculosis Association

One of the most important factors in the success of any business, whether it be a profit-making enterprise or a philanthropic agency, is the permanence of qualified personnel. Indeed, this factor is particularly important in the work of tuberculosis associations, for the success of their programs depends directly upon the skills of their staff.

Perhaps we who serve on association boards are not as conscious of this fact as we should be, but we cannot help but become aware of it if we observe the problems that arise when valuable staff workers leave us. Some of these changes, of course, are desirable—when a worker moves to a better job at another association. But others represent outright losses of skilled personnel to outside employment.

Why does this latter group leave? In some cases, a higher salary offer may be responsible. But in many others, fringe benefits (which are tax-free), rather than direct pay, are the cause.

Our Responsibility

With the conviction that we have a responsibility to make our staff positions as attractive as possible, I should like to direct your attention to a benefit that every tuberculosis association can offer to its employees—a good retirement program at a reasonable cost.

Such a program is offered by the National Tuberculosis Association annuity program, which is available to all employees of all affiliated tuberculosis associations. This plan, covered by a master contract, has been set up by the NTA with the Metropolitan Life Insurance Company. At the present time, 130 affiliated associations, both state and local, are participating. As of November 1, 1957, about 700 employees of these associations, together with those of the NTA, were covered by this annuity plan.

When you realize that there are some 2,000 affiliated associations with paid employees, you can readily see that we are not doing a very good job of providing our employees with adequate retirement coverage.

A few associations may have their own retirement plan. Some other, smaller associations are staffed with part-time paid workers; some are manned by volunteers. However, it is important that the larger number of our affiliated associations give careful consideration to this subject of retirement.

With some 700 people covered in the NTA plan, it is evident that the program is a thing of permanence. The NTA is not going to abandon the plan, nor shift to some other kind. The present plan has been carefully appraised in two independent surveys and has been compared with the annuity plans of other health agencies similar to our own. Each of these surveys has shown that our plan is a good one, both for the employee and for the association, and that the cost to each party is fair with respect to the benefits provided.

Advantages of the NTA Plan

Since many insurance companies offer retirement programs, let me point out some of the advantages of participating in one that involves many groups working in the same field.

First, an employee can go anywhere within the structure of the organization and carry his retirement program right with him. This is a benefit that works both ways. It enables a young and growing employee to accept deserved opportunity to advance in the field without losing his accumulated annuity benefits. On the other hand, when we do lose an employee by advancement, we have an attractive opening for another person. As a matter of fact, some local associations have actually adopted the NTA annuity program in order to get the person they wanted for their staff.

Second, the NTA plan was developed as the most generally suitable in terms of cost and benefits. And since the NTA handles a large part of the clerical work involved, participation in this plan represents a saving to tuberculosis associations.

Third, a good annuity plan serves as a supplement to salary income. The salaries we pay in our associations are not always competitive with those offered in other fields of employment. While we should attempt to be as competitive as possible, we can often hold qualified people through added employment supplements. The NTA annuity plan is one such supplement. Its continuity is more advantageous than plans offered in industry, which are usually restricted to the company itself. When you change jobs in the industrial field, you may take up another retirement program with your new employer, but you do so in a higher age bracket at either higher cost or reduced annuity.

Fourth, for both the association and the employee, the NTA program is a bargain. The cost to both parties is low, and if the employee leaves his job before retirement age, he has two options: (1) he may elect the

NTA Annual Meeting

The March issue of the *Bulletin* will contain the Preliminary Program for the Annual Meeting of the National Tuberculosis Association, to be held in Philadelphia, Pa., May 18-22, together with articles on various activities connected with the meeting.

In order that the Preliminary Program may be as complete as possible, the March issue will be printed about a week later than usual.

Full information about hotel reservations appeared in the November, 1957, *Bulletin*. If anyone planning to attend the meeting has not yet made a reservation, he should do so as soon as possible. Reservation blanks can be obtained from the NTA, 1790 Broadway, New York 19, N. Y.

cash surrender value of the annuity, which returns his contributions plus interest and returns to the association its contribution plus interest, or (2) he may elect a deferred paid-up annuity, which will pay retirement benefits at age 65 based on both his own and the employer's contribution.

Setting up a fair retirement program for its employees is a board responsibility that must be faced. Retirement plans are no longer considered luxury items; they have become a permanent part of almost all employment practices. What about tuberculosis association employees, who through their loyalty and hard work are responsible for the success we have attained? Aren't they entitled to the same benefits as the employees of a profit-making organization?

Even though you may have studied this problem in the past and decided not to join the NTA annuity program, isn't it important that you survey the whole plan again? Perhaps you have gone in on the social security program, but is that enough? Social security is a relatively small amount for retirement, even at the top level, because of the shrinking value of the dollar. A sound annuity program, coupled with social security, will provide a more adequate retirement fund.

Details of the NTA annuity program—what it is, what it does, who may be covered, how to join—are all available to you. Your executive secretary knows how to get this information and can provide you and the other members of your board with full details of the plan for your study. Why not get this at once?

Alan Gregg Fund

The National Health Council has established a special fund in honor of the late Dr. Alan Gregg, formerly chief of the division of medical sciences for the Rockefeller Foundation. Contributions to The Alan Gregg Fund will be used to support the NHC's health careers program, which is designed to help meet the acute shortage of qualified health personnel in the United States.

SCIENTISTS AT WORK

When the talk centers on "hot" drugs in the Department of Pharmacology at the University of Chicago, no one thinks of contraband. On the contrary, a research project using one of the newest tools available for the study of disease is under discussion.

"Hot" drugs, in the scientific vernacular of the day, are radioactive drugs; that is, drugs in which a by-product of atomic energy has been introduced in order to "see" what happens to the drug after it has been taken.

The work at the University of Chicago is under the direction of Dr. Lloyd J. Roth, head of the Department of Pharmacology, who receives a medical research grant from the National Tuberculosis Association to aid his studies.*

Dr. Roth's procedure is to substitute a radioactive atom for one of the normal atoms in the drug. The drug is given to an animal in a glass metabolic cage so constructed that all waste eliminated from the body can be collected. Then, with the aid of a Geiger counter, it is possible to determine what happened to the drug in the body. Most of the work so far has been done with mice and guinea pigs, but a few patients about to undergo surgery have also been given small amounts of "hot" drug. Its disposition has subsequently been studied in the tissue removed by surgery.

A former member of the research team at Los Alamos, N. M., where the atomic bomb was developed, Dr. Roth became interested in the idea of labeling isoniazid when this drug was first announced in 1952. With the cooperation of the Atomic Energy Commission, a batch of isoniazid was labeled with radioactive Carbon^{14} at Los Alamos, and Dr. Roth and his associates at the University of Chicago started their experiment.

*A special contribution from the Snohomish-Island (Wash.) Tuberculosis Association was applied to this study.

They found that isoniazid readily spreads through the body and has a special predilection for infected lung tissue, even penetrating the tubercles themselves.

Now, with the aid of the NTA grant, the Chicago investigators are labeling their own isoniazid and have branched out to study both streptomycin and PAS. They plan, too, to

Dr. Lloyd J. Roth

study still other drugs used in tuberculosis treatment. Their work has already provided valuable guide lines to physicians in treating patients.

Sometimes, to break the strain of concentrated study, in the middle of the afternoon someone in the laboratory will fill a glass flask with water and set it on a Bunsen burner. A little later, members of the research team are planning the next step in their venture over steaming cups of tea.

As they drink their tea and engage in stimulating talk, they look out from their laboratory to Stagg Field, the football stadium where the first atomic stockpile was built. The energy released that day has led not only to atomic bombs, but also to "hot" drugs and other medical uses which are helping in the conquest of disease.—A.S.F.

Mr. Hudson Retires

Executive of the Hawaii association has been succeeded by David Bowers

Holland Hudson has retired as executive secretary of the Tuberculosis and Health Association of the Territory of Hawaii. He has been succeeded by David A. Bowers.

Mr. Hudson was director of the Division of Rehabilitation of the National Tuberculosis Association from 1938 until 1953, when he left to join the Hawaii association. He first became interested in the problems of the discharged tuberculosis patient in the early thirties, while working as a counselor for a vocational counseling agency in New York. Convinced that rehabilitation programs could be effectively carried on in the tuberculosis hospital, he became director of social and economic services of the Kennon Dunham Hospital, the tuberculosis hospital for Hamilton County, Ohio, in 1935.

Mr. Bowers had been executive secretary of the Plymouth County (Mass.) Health Association since 1953. Prior to this he had been rehabilitation director of the Massachusetts Tuberculosis and Health League, rehabilitation director of the Westfield State Sanatorium, and director of local associations for the Wisconsin Anti-Tuberculosis Association.

He holds a B.S. in psychology from Tufts University.

Mr. Bates Resigns

Executive of the Vermont association is succeeded by Michael Marcinkowski

James H. Bates has resigned as executive director of the Vermont Tuberculosis and Health Association to become assistant to the dean of the medical school of the University of Vermont. He has been succeeded by Michael F. Marcinkowski.

Mr. Bates had been executive director of the Vermont association since 1950. Prior to this, he was a field consultant for the Maine Public Health Association. He holds a master's degree in education from the University of Maine.

Mr. Marcinkowski has been program director of the Vermont association since 1956. Formerly he was a rehabilitation consultant for the Berkshire County (Mass.) Tuberculosis Association. He is a graduate of the University of Massachusetts.

Dr. William P. Shepard, formerly president of the National Tuberculosis Association, has been appointed a member of the National Advisory Heart Council by Surgeon General Leroy E. Burney.

Leo C. Kaye, formerly assistant director of the Bergen County (N.J.) Tuberculosis and Health Association, has been appointed coordinator of field services for the New Jersey Tuberculosis and Health Association.

Sumner G. Whittier, former lieutenant governor of Massachusetts, has been appointed Administrator of Veterans Affairs. He succeeds Harvey V. Higley, who recently resigned.

Mrs. Frances Ogasawara, formerly a health educator with the Tuberculosis League of Waterbury (Conn.), has been appointed assistant director of health education for the Massachusetts Tuberculosis and Health League.

Dr. Henry Boswell, of Sanatorium, Miss., former president of the National Tuberculosis Association and of the American Trudeau Society, died in December.

Telford A. Davis has been appointed program consultant for the New Mexico Tuberculosis Association. He was one of the first recipients of a health education scholarship to Michigan University offered by the New Mexico association.

Mrs. Beryl Downey, formerly executive secretary of the Bronx Tuberculosis and Health Committee and associate in the Rehabilitation Division of the National Tuberculosis Association, has been appointed executive director of the Queensboro Council for Social Welfare.

Miss Adelma E. Johnson, director of Christmas Seal Sale and administrative assistant of the Nassau (N.Y.) Tuberculosis, Heart and Public Health Association, died on November 27. She had served the association for 36 years.

Mrs. Solomon Barkin has been appointed social service director for the New York region of the National Jewish Hospital at Denver.

Ray M. Amberg, a member of the executive committee of the Minnesota Tuberculosis and Health Association, has been named president-elect of the American Hospital Association.

Mrs. Bonnie Rising, formerly on the staff of the Lafayette *Courier,* has been appointed community relations director of the Marion County (Indianapolis, Ind.) Tuberculosis Association. Mrs. Rising has also done advertising agency and radio work.